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	155287	A. BUILDING 00 B. WING	05/04/2011

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F0000	This visit was for the Investigation of Complaint IN00089581. Complaint IN00089581-Substantiated. No deficiencies related to the allegation are cited. Unrelated deficiency cited. Survey dates: May 3 & 4, 2011 Facility number: 000185 Provider number: 155287 AIM number: 100290840 Survey team: Janet Adams, RN, TC Kathleen Vargas, RN Census bed type: SNF/NF: 99 Total: 99 Census payor type: Medicare: 16 Medicaid: 66 Other: 17 Total: 99 Sample: 9 This deficiency reflects state findings	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2 Quality review completed on May 5, 2011 by Bev Faulkner, RN			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to alarms not in place correctly for 2 of 6 residents with alarms in the sample of 9, grip strips not in place for 1 of 3 residents with orders for grip strips in the sample of 9, Dycem not in place for 1 of 3	F0323	May 17th, 2011This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied**1.Corrective action accomplished for Resident affected by the alleged deficient practice:** Resident E: Staff educated by SDC to not leave resident unattended in the bathroom. Dycem was replaced on wheelchair and auto brakes were discontinued on chair due to decline in mobility. Plan of care updated. Resident B: Grippy strips placed in front of stationary chair. Plan of care updated.Resident D: Care plan	05/20/2011

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	residents with orders for Dycem in the sample of 9, wheelchair auto locks not in place for 1 of 1 residents with orders for wheelchair auto locks in the sample of 9. The facility also failed to ensure adequate supervision was provided related to supervising a resident on the toilet for 1 of 1 residents in the sample of 9 who sustained a fall from the toilet. (Residents #B, #D, and #E) Findings include:		amended to include his jacket as an acceptable place to clip wheelchair alarm due to him wearing a jacket much of the time. **2. How Facility reviewed all residents who could be affected by the same alleged deficient practice.**Care guide rounds are done Monday through Friday by departmental staff to review fall prevention equipment in place. Facility identified all residents that had Dycem, grippy strips, alarms and auto lock brakes. Audit completed to verify that mentioned protective equipment was in place by unit managers.**3. A systemic change the facility has made to ensure the alleged deficient practice does not occur.**New orders are reviewed Monday through Friday during change of condition by IDON, Unit Managers, SDC and MDS to ensure all new orders received for fall prevention equipment have been implemented on care guides, care plans and TAR. A physical check of the intervention is done to ensure device is in place.Clinical staff will be in-serviced on protocol related to resident having wheelchair alarms and toileting assistance. Department Heads will be inserviced on care guide use and rounds by SDC and/or nursing administration. Clinical staff will be in serviced on care guide use and rounds by SDC to ensure equipment in place.Staff	

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	1. During an observation on 5/4/11 at 8:50 a.m., CNA #2 and QMA #1 were transferring Resident #E from the wheelchair to the bed. CNA#2 and QMA #1 transferred the resident using a gait belt into the bed. After the resident was in bed, the cushion on top of the seat of the wheelchair was lifted. There was no Dycem (thin pad to prevent slipping) on top of or under the wheelchair cushion. There was a sensor alarm		Development Coordinator/Nursing Administration and rehab services manager will educate nursing staff and therapist on above system during orientation and as indicated for compliance.**4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur.**Nursing Administration will monitor/ audit all residents with a WC alarm, dycem, auto breaks and grip strips. Audits will be conducted Mon through Fri 1X per day for 4 weeks then 3X per week for 4 weeks then weekly for 4 weeks. If compliance threshold of 100% is achieved for 1 month following the initial 12 weeks, the QA committee will determine if further audits and or frequency of audits are necessary. **5. By what date the systemic changes will be completed.** Date of compliance is May 20th, 2011.	

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	pad under the cushion. There was no Dycem under the sensor pad. There were no auto lock brakes on the wheelchair. On 5/4/11 at 9:05 a.m., the Unit Director entered the resident's room. The Unit Director indicated there were no auto locks on the resident's wheelchair. When interviewed at this time, the Unit Director indicated the resident recently received a new wheelchair from Hospice and auto locks were not			

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	in place. The Unit Director indicated the Dycem should have been in place. The record for resident #E was reviewed on 5/3/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, mild dementia, falls, high blood pressure, atrial fibrillation (an irregular heart beat), and diabetes mellitus. Review of the 5/11 Physician Order Statement indicated there			

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	were Physician's orders for the resident to have auto locks to the wheelchair and a Dycem under the wheelchair cushion. A Physician's order was written on 1/28/11 for the resident to have a personal alarm to the wheelchair. The resident's current care plans were reviewed. A care plan initiated on 12/8/10 indicated the resident was at risk for falls and new injuries due to impaired mobility and weakness. The care plan			

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	was last updated with a goal date of 5/20/11. Care plan approaches included for the resident to have auto lock brakes on the wheelchair. The 5/4/11 care assignment sheets for resident were reviewed on 5/4/11 at 9:05 a.m. The assignment sheet indicated there was to be Dycem in the resident's wheelchair and the resident was to have a pressure reducing cushion in the high back wheelchair with auto lock brakes.			

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	The 2/25/11 Minimum Data Set (MDS) significant change assessment indicated the resident BIMS (assessment of cognitive patterns) score was 10. A score of 10-12 indicates the resident's cognitive status was moderately impaired. The assessment also indicated the resident required extensive assistance of two staff members for transfers and toilet use. The Care Area Assessment completed with the MDS assessment indicated the			

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	resident had multiple falls and was at high risk for falls. A 1/27/11 Fall Risk Evaluation indicated the resident had 1-2 falls in the last 90 days, had a history of a hip fracture, and decreased lower extremity strength. The evaluation also indicated the resident received anti-depressant medication, medication to treat high blood pressure, and medications for diabetes mellitus. The evaluation indicated the resident's			

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	last fall was 1/22/11. The resident's total score was 22 , which indicated the resident was at high risk for falls. The 2/2011 Nurses' Notes were reviewed. An entry made on 2/7/11 at 7:40 a.m., indicated the Nurse was called to the resident's room by a family member who stated they heard a noise and noted the resident was on the floor. The resident was sitting on her buttock resting her back on the bathroom door and the resident			

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	stated she was "tired of sitting on the stool." An IDT (Interdisciplinary team) note was completed on 2/8/11. The IDT note indicated the team met to review the resident's fall on 2/7/11. The note indicated the resident was found on the floor and stated she was trying to get off the toilet. The investigation indicated a CNA left the resident on the toilet unassisted. When interviewed on 5/4/11 at 11:10 a.m., the			

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	acting Director of Nursing indicated the resident was on the Falling Star Program. When interviewed on 5/4/11 at 2:20 p.m., the Assistant Director of Nursing indicated it was the facility protocol not to leave residents who were at risk for falls unattended in the bathroom. 2. Resident #B was observed on 5/3/11 at 9:57 a.m. The resident was seated in a stationary chair in her room. There were no grippy strips on the floor in front of the resident's stationary chair. During continued observations on 5/3/11 at 11:05 a.m., 12:30 p.m. and 3:30 p.m., the resident was seated in the stationary chair in her room, there were no grippy strips			

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	on the floor in front of the chair. On 5/4/11 at 8:30 a.m., the resident was observed seated in the stationary chair in her room. There were no grippy strips on the floor in front of her. Further observation indicated the sensor alarm pad that the resident was sitting on was not connected to the alarm box. Interview with LPN #1 on 5/4/11 at 8:30 a.m., indicated there were no grippy strips on the floor in front of the resident's stationary chair and the sensor alarm pad was not connected to the alarm box. LPN #1 indicated the sensor alarm pad should be connected to the alarm box and also indicated there should be grippy strips on the floor. The record for Resident #B was reviewed on 5/3/11 at 1:30 p.m. The resident had diagnoses that included, but were not limited to, hypertension (high blood pressure), anemia and dementia. The form titled, "Interdisciplinary Progress Notes" was reviewed. There was a note, dated 2/5/11 at 3 p.m., that indicated the resident fell from the stationary chair on 2/3/11. Further review of the "Interdisciplinary Progress Notes" indicated a progress note, dated 2/14/11 at 9:45 a.m., indicated the resident fell on			

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	2/13/11. She was found sitting on her buttocks facing the stationary chair. She indicated that she had gotten up from the chair to pick something up off the floor. The form titled "Fall Risk Assessment" was reviewed. The entry, dated 3/8/11, indicated the resident's fall risk was 22 . A resident who scored a 10 or higher was at risk for falls. The intervention portion of the form, dated 3/8/11, indicated, "Scored 22 falls 1/13/11, 2/3/11, 2/13/11. Has STM (short term memory) loss/cognitive impairment & Hx (history) of behaviors R/T (related to) Dementia with psychotic episodes, is forgetful. Has attempts to transfer, pick items off floor. Has bed & chair alarm, bil (bilateral) SR (side rails) with low bed, grippy strips on floor next to bed and recliner. Unable to balance test without physical assist of 1 with standing transfers - weak wobbly/unsteady." Review of the May 2011 Physician Order Sheet indicated the resident was to have a sensory pad to stationary chair. The falls care plan, dated 1/7/11, was reviewed. The interventions to decrease falls included: - pressure alarm to bed and stationary chair, check placement and function every shift - grippy strips in front of stationary chair,			

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	the intervention was dated 2/13/11 The ADON (Assistant Director of Nursing) was informed on 5/4/11 that the fall interventions for the resident were not in place. 3. Resident #D was observed on 5/3/11 at 10:00 a.m. The resident was seated in a wheelchair in front of the nurses' station. The resident had a jacket on. There was a personal alarm attached to the resident's jacket. During continued observations on 5/3/11 at 12:55 p.m. and 3:05 p.m., the resident was seated in his wheelchair with the personal alarm attached to his jacket. On 5/4/11 at 8:25 a.m., the resident was observed seated in his wheelchair in the dining room. The resident had his jacket on and the personal alarm was attached to the jacket. At 12:15 p.m. on 5/4/11, the resident was seated in the wheelchair by the front entrance door. LPN #1 was observed attaching the resident's personal alarm to the resident's jacket. Interview with LPN #1 on 5/4/11 at 12:15 p.m., indicated the resident had just been out with his son. The record for Resident #D was reviewed			

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on 5/3/11 at 11:15 a.m. The resident had diagnoses that included, but were not limited to, high blood pressure, dementia with behaviors, and anxiety.

The form titled "Fall Risk Assessment" was reviewed. The entry, dated 2/18/11, indicated the resident's fall risk was 26, (a score of 10 or higher is at risk for falls). The intervention portion of the form, dated 2/18/11, indicated the resident had a fall on 12/13/10.

Review of the May 2011 physician order sheet indicated the resident was to have a personal alarm in use while in the wheelchair.

The fall care plan, dated 12/10/10, was reviewed. The care plan indicated the resident was at risk for falls related to decreased mobility, history of falls, diagnoses of vertigo and dementia, with poor safety awareness. Interventions to decrease falls included:
- personal alarm in wheelchair
-falling star program
- place personal alarm clip on shirt not jacket due to resident removes jacket

The ADON (Assistant Director of Nursing) was informed on 5/4/11 at 12:30 p.m., the resident's personal alarm was attached to his jacket on 5/3/11 and 5/4/11

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	and not to his shirt, as indicated on the plan of care. 3.1-45(a)(2)			